

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02104
CERTIFICATE OF DEATH
02054

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md. c. LENGTH OF STAY IN ID 2/24-2/28/66 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Calvert County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Maryland d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nellie f. SEX Female g. COLOR OR RACE White h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> i. DATE OF BIRTH 5/29/91 j. AGE (in years last birthday) 74 yrs. k. IF UNDER 1 YEAR Months Days Hours Min. — — — —		4. DATE OF DEATH Month 2 Day 28 Year 1966 l. BIRTHPLACE (County & State, or foreign country) Pr. Frederick Maryland m. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Housewife 11. FATHER'S NAME Uriah Buckler 12. MOTHER'S MAIDEN NAME Henrietta Monnett		13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — 14. SOCIAL SECURITY NO. none 15. INFORMANT Emma Verda Bowen Address Prince Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident 331X DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) —		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State) — — —	
21. I certify that (I) (this hospital) attended the deceased from 3/10 , 19 45 , to 2/28 , 19 66 that (I) (we) last saw the deceased alive on 2/27 , 19 66 , and that death occurred at — M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. George Weems 22c. PHYSICIAN'S NAME (Type) Dr. George Weems		22b. DATE SIGNED 2/28/66 22d. ADDRESS Huntingtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF March 2, 1966 23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery 23d. LOCATION (City, town or county) (State) Prince Frederick Md.		24. FUNERAL DIRECTOR A.A. Harbison 25a. REC'D BY REGISTRAR MAR 2 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

10057

10057

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page. The text is mostly centered and occupies most of the page area.]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02105				CERTIFICATE OF DEATH				02055			
1. PLACE OF DEATH a. COUNTY <u>CAVERT</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCE FRED.</u> c. LENGTH OF STAY IN 1b <u>2 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CAVERT NURSING HOME</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>INDIAN HEAD</u> d. STREET ADDRESS <u>Box 419 Rt. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>E</u> Last <u>BOWIE</u>						4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-17-87</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CHARLES Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>THEODORE BOWIE</u>						14. MOTHER'S MAIDEN NAME <u>MOLLIE SANDERS.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>				16. SOCIAL SECURITY NO. <u>none.</u>		17. INFORMANT Address <u>JANE MADOWELSKI IRONSIDES Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive C.V. disease</u> 443X OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>A.S. Cardiac Failure</u> OUE TO (c) <u>Aphyria</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-19</u> , 19 <u>66</u> , to <u>2-4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-3</u> , 19 <u>66</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH C. JETT</u>						22d. ADDRESS <u>PRINCE FREDERICK</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>BURIAL</u>		<u>2-6-66</u>		<u>CHICAMUXEN M.E.</u>		<u>CHICAMUXEN Md</u>					
24. FUNERAL DIRECTOR ADDRESS <u>AREHART I.N.C. LAPLATA Md</u>						25a. REC'D. BY REGISTRAR <u>FEB 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

05052

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THESE ARE THE
JAMES EARL RAY
MILITARY SERVICE
RECORDS
FOR THE
PERIOD 1954-1968

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/STP

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02106											
1. PLACE OF DEATH a. COUNTY Calvert						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS 04-1					
3. NAME OF DECEASED (Type or print) First Middle Last Charles Henry Coates						4. DATE OF DEATH Month Day Year 2 7 1966					
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec/12-1897 68		9. AGE (In years last birthday) yrs. Months Days		10. IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Coates						14. MOTHER'S MAIDEN NAME Mary Jones					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 217-32-0497		17. INFORMANT Address Mazora Coates -Owings- Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 7824 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/1 , 19 66 to 2/7 , 19 66 that (I) (we) last saw the deceased alive on 2/3 , 19 66 and that death occurred at 7:45 AM, from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 2-10-66		23c. NAME OF CEMETERY OR CREMATORY Patuxent Church- Cem.		23d. LOCATION (City, town or county) (State) Huntingtown Md			
24. FUNERAL DIRECTOR P. E. Sewell-Prince Frederick, Md						25a. REC'D BY REGISTRAR FEB 10 1966		25b. REGISTRAR'S SIGNATURE [Signature]			

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02107 02057											
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b one day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barstow				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) CYNTHIA MAY DOUGLAS			First Middle Last			4. DATE OF DEATH Feb. 22 19 66			Month Day Year		
5. SEX F		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/8/65		9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland, Calvert		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMMY DOUGLAS						14. MOTHER'S MAIDEN NAME Gloria Gray					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother			Address Barstow, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X Pneumonia DUE TO (b) Hypertension & aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 2-21-66 , 19 66 , to 2-22-66 , 19 66 , that (I) (we) last saw the deceased alive on 2-22-66 19 66 , and that death occurred at 4A M, from the causes and on the date stated above.											
22a. SIGNATURE Anthony E. Scovel						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) ESSAM F. SO-DANALOO		
22d. ADDRESS Prince Frederick Md.			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. M.D. PHYS. <input type="checkbox"/>			22g. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-24-66		23c. NAME OF CEMETERY OR CREMATORY Carrolls Church Cem		23d. LOCATION (City, town or county) Barstow		(State) Md		23e. REG'D. BY REGISTRAR	
24. FUNERAL DIRECTOR Anthony E. Scovel						24a. ADDRESS Prince Frederick Md.		24b. REG'D. BY REGISTRAR FEB 25 1966		24c. REGISTRAR'S SIGNATURE Charles Judge	

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02108										02058	
1. PLACE OF DEATH a. COUNTY <u>Calvert</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Calvert</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>				c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>—</u>						d. STREET ADDRESS <u>—</u>					
3. NAME OF DECEASED (Type or print)			First <u>Ethel</u> Middle <u>Mac</u> Last <u>Dowell</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>8</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 3 1902</u>		9. AGE (in years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Samuel T. Shutt</u>						14. MOTHER'S MAIDEN NAME <u>Mary Dowell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Bonnie C. Dowell, Lusby, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Breast</u> <u>170X</u> DUE TO (b) <u>Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Aug 1958</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>65</u> , to <u>Feb</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 8</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Page C. Jett</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>2-9-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Page C. Jett</u>						22d. ADDRESS <u>Prince Frederick, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Feb 12 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Paul's Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Lusby Calvert Co. Md.</u>			
24. FUNERAL DIRECTOR <u>W.D. Harkness & Son</u>						ADDRESS <u>Mutual Bldg 34</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

80080

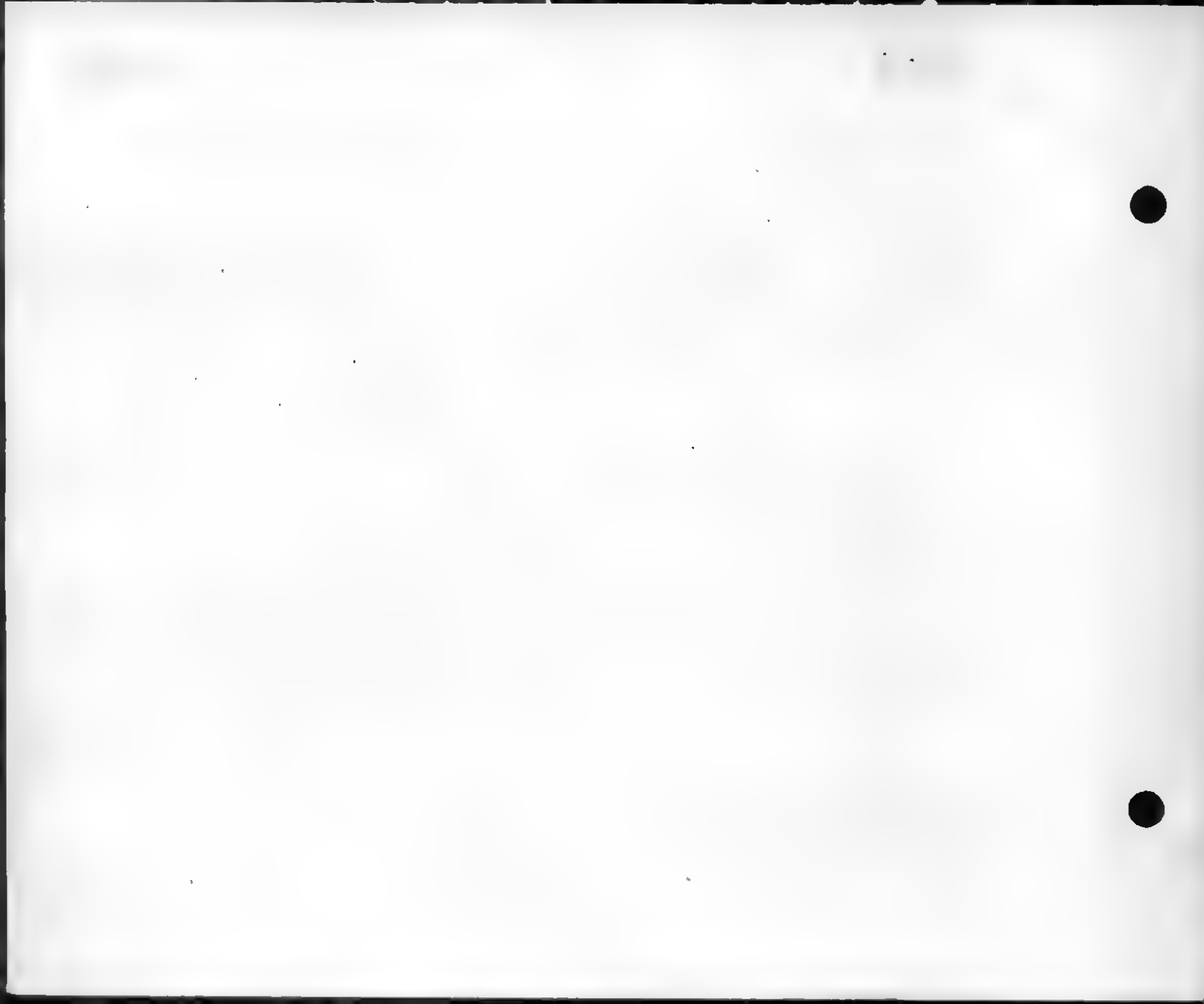
80150

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Timothy Gray</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>10/29/65</u> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			4. DATE OF DEATH <u>Feb. 13 1966</u> Month Day Year 9. AGE (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days _____ Hours _____ Min. _____ 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Donald Gray</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Patricia Beverly Lusby, Maryland</u> Address _____			14. MOTHER'S MAIDEN NAME <u>Patricia Beverly</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>490X</u> DUE TO <u>Bilateral pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____			21. I certify that (I) (this hospital) attended the deceased from <u>birth</u> , 19 <u>65</u> , to <u>2-13-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-12</u> , 19 <u>66</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Dr. Issam F. el Damalouji</u> 22b. DATE SIGNED _____ 22c. PHYSICIAN'S NAME (Type) <u>Dr. Issam F. el Damalouji</u> 22d. ADDRESS <u>Prince Frederick, Md.</u> 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>2-15-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Church Cem</u> 23d. LOCATION (City, town or county) (State) <u>Lusby Md</u>				
24. FUNERAL DIRECTOR <u>Anthony E. Sewell - Prince Frederick-Md</u> ADDRESS _____ 25a. REC'D BY REGISTRAR <u>FEB 17 1966</u> DATE _____ 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			25c. REGISTRAR'S SIGNATURE _____				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02110

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02060

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle EDWARD Last HODGES		4. DATE OF DEATH February 17 19 66		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 19, 1885	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 11 Days 19		11. IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Willard Hodges		14. MOTHER'S M maiden NAME Vida Elizabeth Watson	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-45-4194		17. INFORMANT Mrs. Ethel Cox	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) OUE TO c) OUE TO		19. INTERVAL BETWEEN ONSET AND DEATH		20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 2/18/66		23. LOCATION (City, town or county) (State) Baltimore Calvert Co. Md.	
24. FUNERAL DIRECTOR A.A. Harkness & Son		25a. REC'D BY REGISTRAR FEB 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



1. PLACE OF DEATH a. COUNTY <u>Cabert</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabert</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Leonards</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>_____</u>		d. STREET ADDRESS <u>_____</u>	
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>Francis</u> Last <u>Hooper</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1889</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>_____</u> Days <u>_____</u> Hours <u>_____</u> Min. <u>_____</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cabert Co., Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Silas B. Hooper</u>		14. MOTHER'S MAIDEN NAME <u>Ida E. Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>212-28-0438</u>	
17. INFORMANT <u>Lewis Jeff - St. Leonards, Ind.</u>		Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4-00</u> DUE TO <u>Chronic illness</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>_____</u> DUE TO (c) <u>_____</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 29</u> , 19 <u>66</u> , to <u>Feb 1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 1</u> , 19 <u>66</u> , and that death occurred at <u>_____</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>R. G. Villagrana</u>		22b. DATE SIGNED <u>2/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. G. Villagrana</u>		22d. ADDRESS <u>St. Leonards, Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 4 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Watson Memorial</u>	23d. LOCATION (City, town or county) (State) <u>Island Creek, Ind.</u>
24. FUNERAL DIRECTOR <u>G. G. Wackman & Son</u>		25a. REC'D BY REGISTRAR <u>Feb 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



1-6
FOR STATE
HEALTH DEPT.

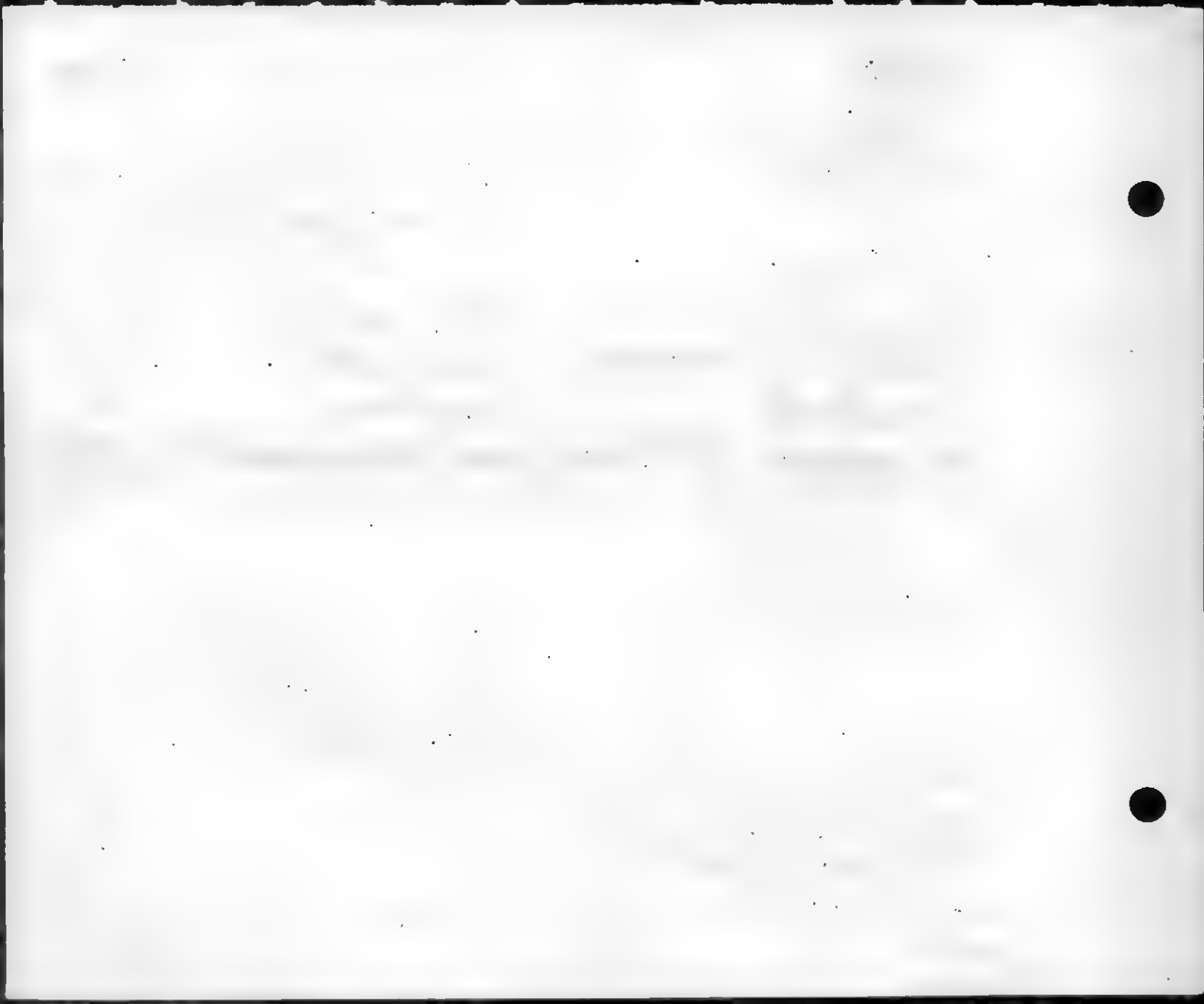
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02062

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Md</i> c. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Murphy</i>		c. LENGTH OF STAY IN 1b <i>3445</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert's Hospital</i>		e. STREET ADDRESS <i>Island Creek P.O.</i>	
3. NAME OF DECEASED (Type or print) <i>Timothy Matthews Murphy</i>	4. DATE OF DEATH Month <i>2</i> Day <i>19</i> Year <i>1966</i>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 1, 1920</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welding</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Steam Fitter</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Murphy</i>		14. MOTHER'S MAIDEN NAME <i>Mary Kane</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>579-14-2151</i>	
17. INFORMANT <i>Joseph Murphy, Edgewater, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Internal injuries of chest</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) <i>and asphyxiation</i> UNDERLYING CAUSE LAST. (c) <i>Chest filled with clots of blood</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Trunk hit a tree while driving to work Highway Martine, Md</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>6:45 a.m. 7/19/66</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway Martine, Md</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H.W. Ward</i>		22. DATE SIGNED <i>2/19/66</i>	
EXAMINER'S NAME (Type) <i>H.W. Ward</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE THEREOF <i>Feb. 23, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Archie National Cemetery</i>	
23d. LOCATION (City, town or county) (State) <i>Bellevue</i>		25a. REG'D BY REGISTRAR <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <i>At. Harbison & Son, Port Republic, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>FEB 23 1966</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02113 CERTIFICATE OF DEATH 02063

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN ID <u>6 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Calvert County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesapeake Beach</u> d. STREET ADDRESS <u>Chesapeake Beach, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillie Avolia Stepney</u>		4. DATE OF DEATH Month Day Year <u>2 9 19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/13/03</u>
9. AGE (In years last birthday) <u>63 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Stepney</u>		14. MOTHER'S MAIDEN NAME <u>Maria Lake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ida Holland</u>		Address <u>Chesapeake Beach, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>morning Biliary Sucts</u> <u>1551</u> DUE TO (b) <u>and Circulatory Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/5/66</u> , 19 <u>66</u> to <u>2/9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/8</u> , 19 <u>66</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Osman Z. Ersoy, M. D.</u>		22b. DATE SIGNED <u>2/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Osman Z. Ersoy, M. D.</u>		22d. ADDRESS <u>Prince Frederick, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2 -12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Edmond Church Cem</u>	23d. LOCATION (City, town or county) (State) <u>Sunderland - Md.</u>
24. FUNERAL DIRECTOR <u>Linkney E. Smith</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

DOMESTIC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AJS (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02114											
02064											
1. PLACE OF DEATH a. COUNTY Calvert					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach, Maryland						
c. LENGTH OF STAY IN 1b 2/20-2/22/66					d. STREET ADDRESS Calvert County Hospital						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Wilbert Leon Ward					4. DATE OF DEATH Month Day Year 2 22 19 66						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/99		9. AGE (In years last birthday) 66 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Plummer Ward					14. MOTHER'S MAIDEN NAME Susie Wood						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-9647		17. INFORMANT Mrs. Sarah Ward North Beach, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart heart failure</i> 443X DUE TO (b) <i>Hypertensive cardiac vascular</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>2-20</i> to <i>2-22</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>2-20</i> , 19 <i>66</i> , and that death occurred at <i>11:20A</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>[Signature]</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/22/66				
22c. PHYSICIAN'S NAME (Type) <i>Dr. Villars</i>					22d. ADDRESS <i>St. Remond</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 24, 1966		23c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Chr. Cemetery		23d. LOCATION (City, town or county) (State) Owings Maryland					
24. FUNERAL DIRECTOR <i>Hutchins Funeral Home</i>					25a. REC'D BY REGISTRAR DATE FEB 25 1966		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02115 CERTIFICATE OF DEATH 02065

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md. c. LENGTH OF STAY IN 1b 35 minutes d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Maryland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas H. Williams		4. DATE OF DEATH 2 12 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 9 1894
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (County & State, or foreign country) Maryland (Calvert Co.)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Watt Williams		14. MOTHER'S MAIDEN NAME Elizabeth Hutchins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-10-0739	
17. INFORMANT Mrs. Lete Riggs Williams, Prince Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO CORONARY THROMBOSIS - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 2 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-12 , 19 66 , to 2-12 , 19 66 , that (I) (we) last saw the deceased alive on 2/12 19 66 , and that death occurred at 4:40 M, from the causes and on the date stated above.			
22a. SIGNATURE R Deutharreal		22b. DATE SIGNED 2/12/66	
22c. PHYSICIAN'S NAME (Type) R Deutharreal		22d. ADDRESS St Leonards	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 14 1966	23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery	23d. LOCATION (City, town or county) (State) Port Republic Md.
24. FUNERAL DIRECTOR A.A. Harkness Sr., Port Republic, Md.		25a. REC'D BY REGISTRAR FEB 15 1966 25b. REGISTRAR'S SIGNATURE g Charles Judge	

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